



PUBLIC HEARING

Professional Conduct Committee Initial Hearing

21 August 2024

Name: BEIRAO MAGRO GOMES SANCHES, Goncalo

Registration number: 254566

Case number: CAS-202397

General Dental Council: Natalie Bird, counsel
Instructed by Terry Symon of IHLPS

Registrant: Not Present
Unrepresented

Fitness to practise: Impaired by reason of misconduct

Outcome: Erased

Immediate order: Immediate suspension order

Committee members: Jane Everitt (Lay) (Chair)
Emili Shatchan (DCP)
Phillip Loughnane (Dentist)

Legal adviser: Alastair McFarlane

Committee Secretary: Paul Carson



1. This is a hearing before the Professional Conduct Committee (PCC) to decide allegations relating to, among other things, the standard of care which Mr Beirao Magro Gomes Sanches provided to Patient A between 2016 and 2020 and his subsequent handling of her complaint.
2. Mr Beirao Magro Gomes Sanches was neither present nor represented at the hearing, which was conducted remotely using Microsoft Teams. Miss Bird, on behalf of the General Dental Council (GDC), submitted that the notification of hearing had been served on him in accordance with the requirements of the General Dental Council (Fitness to Practise) Rules 2006 (the “Rules”) and that the Committee should exercise its discretion to proceed with the hearing, notwithstanding his absence.

Service and absence 19 August 2024

3. The Committee accepted the advice of the Legal Adviser on the requirements of service and proceeding in absence.
4. The notification of hearing was sent to Mr Beirao Magro Gomes Sanches at his registered address by International Special Delivery on 17 July 2024. Royal Mail ‘Track and Trace’ records that the item was delivered on 23 July 2024. A link to download a copy of the notification of hearing was also sent to Mr Beirao Magro Gomes Sanches on 17 July 2024 using two email addresses which the GDC held for him.
5. The notification informed Mr Beirao Magro Gomes Sanches of the time, date and (remote) venue of this hearing and of his right to attend and to be represented, among other rights. The notification stated: *“In accordance with Rule 13 you are required to confirm whether you will be attending the hearing and/or whether you will be represented. Please confirm this by 26 July 2024.”* An information sheet accompanying the notification explained that:

“...You do not have to come to your hearing, but it is usually in your best interests to do so because of the potential impact on your registration and your ability to work.

...if you decide not to attend the hearing (either in-person, by telephone or by video-link), the Practice Committee may proceed and make a decision in your absence as this is permitted under the Rules...”. The notification of hearing had informed him that:

“...if you do not attend the hearing this is likely to be severely prejudicial to your case...”.

6. The Committee was satisfied that the notification of hearing contained the prescribed information under Rule 13 of the Rules and that it had been served on Mr Beirao Magro Gomes Sanches in accordance with Rule 65 by virtue of it being posted to his registered address. The next consideration for the Committee was whether to proceed with the hearing notwithstanding his absence. This is a discretion which must be exercised with great care and caution.
7. The Committee was satisfied that the GDC had made all reasonable efforts to send notice of this hearing to Mr Beirao Magro Gomes Sanches. There had been no response or engagement from him, whether by the stated deadline of 26 July 2024

or at all. There has been no communication or engagement from him (or any representative on his behalf) at all in these proceedings despite numerous reminders. There was no application for a postponement and there was nothing to suggest to the Committee that adjourning the hearing would make Mr Beirao Magro Gomes Sanches's attendance or engagement any more likely at a future date. Having regard to all the circumstances, including the need for the expeditious disposal of proceedings and the convenience of the six witnesses who had been warned to give evidence this week, the Committee determined that it would be fair and in the public interest to proceed with the hearing, notwithstanding the absence of Mr Beirao Magro Gomes Sanches.

Amendment to the Charge 19 August 2024

8. Miss Bird then applied for the Charge contained in the notification of hearing to be amended under Rule 18 of the Rules to correct two typographical errors. The first was at the stem of charge 1, which truncated the period which had been referred by the Case Examiners ("22 June 2016 to 16 November 2020" rather than "22 February 2016 to 16 November 2020"). The second was at charge 1(d), which had incorrectly been numbered as an additional charge 1(c). The proposed amendments had been sent to Mr Beirao Magro Gomes Sanches in advance of the hearing.
9. The Committee having accepted the advice of the Legal Adviser on its powers under Rule 18 acceded to Miss Bird's application and amended the charge. Having regard to the merits of the case and the fairness of the proceedings, the Committee was satisfied that the required amendments could be made without injustice.

The factual inquiry

10. The Committee received witness statements from the following witnesses, each of whom were called to swear or affirm the truth of their evidence and to be examined on the content of their witness statements:
 - Mr A, the adult son of Patient A;
 - Ms B, practice manager between 2016 to July 2021 at the dental practice where Mr Beirao Magro Gomes Sanches allegedly provided treatment to Patient A;
 - Mr P. Hyde, a complaints officer at the GDC's Dental Complaints Service (DCS);
 - Ms. S. Rasul, a fitness to practise caseworker at the GDC;
 - Ms. Y. Granger, a paralegal at the GDC's In-House Legal Presentation Service.
11. In addition, the Committee heard oral evidence from Professor Ian Brook BDS MDS PhD FDSRCS (England), instructed by the GDC for an expert opinion. His report dated 26 March 2024 was also before the Committee.
12. Patient A was not called to give evidence neither had the GDC obtained any statement from her. Miss Bird stated to the Committee that this was because of her advanced age and because she had expressed an unwillingness to participate in the proceedings as a witness as she would find this distressing. The GDC instead relied on the evidence of her son Mr A who made the initial complaint on her behalf.

13. Aspects of the witness statements of Mr A and Ms B were hearsay, in that they were referring to matters which they had not directly witnessed with no evidence from Patient A or the Practice owner being available to the Committee. Ms Bird for the GDC applied for their admission pursuant to Rule 57(2). There was therefore a need for the Committee to consider whether it would be fair to allow those parts of their witness statements to be admitted in evidence. The Committee accepted the advice of the Legal Adviser on the admissibility of hearsay in these proceedings and retired to consider its decision.
14. The Committee determined that the witness statements of both Mr A and Ms B were admissible in their entirety. Although parts of those statements contained hearsay evidence, this was largely background or contextual information which was not the sole or decisive evidence in support of the charges against Mr Beirao Magro Gomes Sanches. Patient A's advanced age and the apparent distress participating in these proceedings might cause her were, in the Committee's judgment, reasonable considerations for the GDC when it decided not to obtain a statement from her in support of its case.
15. As with the rest of the evidence, the question of what weight, if any, should be attached to the hearsay would be a matter for the Committee to decide when it retired to deliberate on the facts.

Findings 21 August 2024

16. The Committee accepted the advice of the Legal Adviser on the factual inquiry.
17. The burden was on the GDC to prove each allegation on the balance of probabilities and the Committee reminded itself that Mr Beirao Magro Gomes Sanches's absence added nothing to the GDC's case and was not to be taken as indicative of any admission.
18. I will now announce the Committee's findings in relation to each head of charge:

1.	AMENDED TO READ: <i>You failed to provide an adequate standard of care to Patient A, from 22 February 2016 to 16 November 2020, in relation to:</i>
1.(a)	<p><i>Assessment and planning;</i></p> <p>Found proved.</p> <p>Patient A initially attended Mr Beirao Magro Gomes Sanches in 2016 to have her upper set of partial dentures replaced with an implant supported bridge, with a total of four implants being placed by him in her upper jaw. In 2019 she received the same treatment from him to her lower jaw, with a total of six implants being placed there.</p> <p>The treatment was unsuccessful with both the temporary and definitive upper and lower bridgework fracturing or breaking, and with some of the supporting teeth becoming chipped or fractured. These complications occurred over a period of approximately six years whilst Patient A remained under Mr Beirao Magro Gomes Sanches's care with Patient A ultimately requiring remedial work from other dentists.</p> <p>Professor Brook was not critical of the surgical aspects of the placement of the implants, which were utilised by the subsequent treating dentists. Whilst</p>



one of the implants in the upper jaw needed to be removed and replaced by Mr Beirao Magro Gomes Sanches later in 2016, there was no evidence that this was the result of a failure by him to have provided an adequate standard of care. Professor Brook's criticisms related to Mr Beirao Magro Gomes Sanches's wider assessment and planning of the temporary and permanent restorations and bridgework, including *"failure to assess and take any account of Patient A's skeletal pattern and dental occlusion"*.

The Committee accepted the opinion evidence of Professor Brook. There is clearly a duty on all practitioners to provide an adequate standard of care to patients. There was nothing in the clinical records to indicate that Mr Beirao Magro Gomes Sanches had undertaken any adequate assessment and planning in relation to the bite related aspects of the complex and invasive restorative treatment which he was providing to Patient A. Whilst it appears from the clinical records that there had been adequate assessment and planning in relation to the surgical aspects of the implant treatment itself, the records do not show any holistic consideration of Patient A's dentition, both when initially planning treatment in 2016 and 2019 and when assessing the complications which repeatedly presented themselves over a period of years. The Committee accepted the opinion evidence that these complications were *"attributable to inadequate assessment and planning of the prosthodontic aspects of care (specifically the occlusion)"*.

Accordingly, the Committee found this charge proved.

1.(b)

Radiographic practice;

Found proved.

The Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017 placed Mr Beirao Magro Gomes Sanches under a statutory duty to justify and report on the radiographic images which he had requested or taken.

Whilst there was sporadic evidence in the clinical records of justification of the radiographic images he had requested or taken for Patient A throughout the course of her treatment, there was a consistent absence in the records of any corresponding report on those images. In particular, there was no record of any, or any adequate, report on cone beam computer tomogram scans taken around 07/03/16 and 15/07/19 and periapical radiographs taken on: 04/04/16 (x4), 01/08/16 (x2), 21/11/16 (x1), 12/09/16 (x1) and 31/07/19 (x1).

Under questioning Professor Brook stated that the images provided to the Committee were of an acceptable standard. His opinion that the standard of radiographic practice fell far below an acceptable standard was related to non-compliance with the legal duty to report on the radiographs under IRMER regulations, which, given Mr Beirao Magro Gomes Sanches's intermittent attendance at the Practice, the Committee found significant.

The Committee accepted the opinion evidence of Professor Brook that this was in breach of the IRMER Regulations, which are mandatory, and that Mr Beirao Magro Gomes Sanches had therefore failed to provide an adequate standard of care to Patient A in respect of his radiographic practice.

Accordingly, the Committee found this charge proved.



1.(c)

Informed consent; and

Found proved.

The Committee accepted the opinion evidence of Professor Brook that Mr Beirao Magro Gomes Sanches was under a professional duty to obtain informed consent from Patient A, as set out in the GDC's Standards, and that this was an integral aspect of providing care. Informed consent was particularly important in Patient A's case given the complex, invasive and irreversible nature of the proposed treatment, which would also involve substantial financial cost to her.

The GDC put its case on the basis that there had been a failure to obtain informed consent for the treatment provided to the upper jaw in 2016 and a failure to do so again for the treatment provided to the lower jaw in 2019.

The Committee accepted the opinion evidence of Professor Brook that the clinical records in respect of the 2016 treatment do not document an adequate consent process. There was a record of relevant information being provided to Patient A in respect of her proposed treatment of 4 implants and a bridge along with an alternative treatment option of 6 implants and a ceramic bridge. Generic information sheets were also provided but the information given was not sufficiently tailored to Patient A's proposed treatment and also contained information which was not relevant to her. In addition, she was provided with 'Bone graft consent' documentation which erroneously described the graft materials which were to be used as "synthetic" when they were derived from Cow bone and Pig collagen. This was in breach of Patient A's right to know what was to be implanted into her, with the irreversible use of animal products potentially being objectionable on religious or ethical grounds.

Accordingly, the Committee found proved that Mr Beirao Magro Gomes Sanches had failed to obtain Patient A's informed consent in respect of the treatment which was provided to her in 2016.

In respect of the treatment provided in 2019, there was some reference in the clinical records to a treatment plan review and a record that Patient A understood the proposed treatment. Alternative treatment options were recorded in the notes and a review appointment was conducted to verify the treatment plan. Generic but comprehensive information sheets were also provided to her. In addition, the information provided to her relating to the bone graft on this occasion correctly explained the use of animal products in the graft material. A copy of the treatment plan itself was not contained in the clinical records which were before the Committee.

The Committee could not be satisfied from the available evidence that the GDC had discharged its burden of proof in relation to a failure to obtain informed consent in respect of the 2019 treatment. It had not called Patient A to give evidence or otherwise obtained a statement from her in respect of the discussions which might have taken place between her and Mr Beirao Magro Gomes Sanches regarding the 2019 treatment. Neither Mr A nor Ms B were present at Patient A's corresponding appointments and so were unable to



	<p>speak as to what, in anything, was said between her and Mr Beirao Magro Gomes Sanches on those occasions.</p> <p>The Committee could not establish from the available evidence whether it is more likely than not that Mr Beirao Magro Gomes Sanches had failed to provide her with sufficient information to obtain her informed consent. The clinical records broadly indicate that informed consent was obtained and, without further evidence, the Committee is unable to determine either way whether or not any discussion(s) held and information given was adequate for the purpose of establishing informed consent. The absence from the clinical records of a signed treatment plan might reflect a record keeping failing (as opposed to a failure to have obtained informed consent), but that is not what is alleged by the GDC. This charge is therefore not proved in respect of the 2019 treatment.</p> <p>Accordingly, the Committee found this charge proved in relation to a failure to obtain informed consent for the treatment in 2016 but not 2019.</p>
1.(d)	<p><i>Treatment and aftercare.</i></p> <p>Found proved.</p> <p>As set out under charge 1(a) above, there is no criticism of Mr Beirao Magro Gomes Sanches in relation to the adequacy of the surgical aspects of the implant treatment which he provided to Patient A. The criticism from Professor Brook, whose opinion evidence the Committee accepted, was about treatment and aftercare in relation to the restorative work which was placed on top of the implants. There was a prolonged and sustained failure by Mr Beirao Magro Gomes Sanches over a period of six years to reach a diagnosis on why the restorative work kept failing. The treatment which he provided to Patient A also ultimately remained incomplete.</p> <p>Mr Beirao Magro Gomes Sanches had repeatedly failed to consider the occlusion and to assess the case holistically in breach of GDC Standards. There was no evidence of any occlusal diagnosis at the assessment stages or at any of the emergency appointments which Patient A attended when complications with her dentition arose. Instead, Mr Beirao Magro Gomes Sanches only noted in the clinical records the fact that, for example, a tooth had chipped or fractured or that the bridgework had broken. There was no record of any inquiry by him as to why this had happened and why it kept occurring, in contrast to the subsequent treating dentist.</p> <p>Accordingly, the Committee found this charge proved.</p>
2.	<p><i>You failed to respond adequately to Patient A's complaint about her dental treatment.</i></p> <p>Not proved.</p> <p>There was a record before the Committee of an emailed complaint to the Practice submitted on Patient A's behalf by Mr A on 25 June 2020 stating (following on from earlier correspondence with the Practice in the email chain):</p>



"I have just spoken to my mother who has visited your practice today to see [The Practice Principal] regarding the ongoing situation with her teeth. [The Practice Principal] has been very kind in stepping in to make a temporary solution for the 3rd time but the situation has now turned unbearable for my mother with worry. Having spoken to her she has asked me to inform you that she will not pay any more money until the top and bottom teeth have been sorted to her satisfaction.

We will then have to review the situation as the stress this has caused my mother continues to increase as this has now been going on for 4 years, absolute madness..."

There was also a note in the clinical records on 25 June 2020 that Patient A herself had informed to the Practice that she *"was not happy to pay any money for tp she has already pai[d] 20k, advice pt to email PM regarding It."*

The complaint submitted by Mr A was handled by Ms B in her role as practice manager and complaints officer. She replied to him later on 25 June 2020 to acknowledge the correspondence and to state that: *"I will be forwarding this email on to [Mr Beirao Magro Gomes Sanches]"*.

The Committee was satisfied that Mr Beirao Magro Gomes Sanches was under a professional duty under standard 5.3 of the GDC's *Standards for the Dental Team (2013)* (the "Standards") to provide *"a prompt and constructive response"* to patient complaints.

In her oral evidence, Ms B explained that there was a large volume of correspondence and records relating to the handling of this complaint which would have been saved on the contacts tab of the practice management software but she was unable to exhibit in evidence, as she no longer had access to the records. The GDC had not otherwise obtained the records for the Committee as part of these proceedings.

On 31 March 2021, Mr A wrote directly to Mr Beirao Magro Gomes Sanches seeking financial recompense but not detailing the nature of the complaint.

Mr A also contacted Mr Beirao Magro Gomes Sanches over a WhatsApp voice call on a date which he did not record. Mr A's evidence was that Mr Beirao Magro Gomes Sanches was surprised that Patient A had not finished her treatment and that he was reluctant to discuss circumstances surrounding her and any claims that Mr A had made.

The allegation is of a failure to respond adequately to Patient A's complaint about her dental treatment. From the evidence before it, in particular Mr A's account, when he recorded that Mr Beirao Magro Gomes Sanches was surprised that Patient A had not completed her treatment, the Committee was unclear what, if any, details of the complaint had been put to Mr Beirao Magro Gomes Sanches. The thrust of Mr A's evidence was in relation to seeking compensation.

Further, it is clear from the evidence of Ms B that the Committee was not provided with the full documentation on the issue of Patient A's complaint. Ms B was clear that the documentation exists, both in the contacts tab and in practice complaints log, but it was not put before the Committee. There is no



	<p>contemporaneous evidence at all of the nature of the complaint having been put to Mr Beirao Magro Gomes Sanches.</p> <p>In the absence of the documentation and on the limited information before it as to what complaint was put to Mr Beirao Magro Gomes Sanches, the Committee is not satisfied that the GDC has discharged its burden of proof.</p> <p>Accordingly, allegation 2 is not proved.</p>
3.	<p><i>From 21 May 2021 to 27 July 2021, you failed to engage with the Dental Complaints Service about Patient A's complaint.</i></p> <p>Found proved.</p> <p>On 31 March 2021 Mr A escalated the complaint to the Dental Complaints Service (DCS) of the GDC. The Committee accepted the evidence of Mr Hyde on the attempts made by the DCS to contact Mr Beirao Magro Gomes Sanches regarding the complaint.</p> <p>The DCS first contacted Mr Beirao Magro Gomes Sanches on 07/05/21 by email asking him to get in contact by 21/05/21 regarding the complaint. No response was received and so a further email was sent to him on 01/06/21, providing a new deadline for responding of 15/06/21. No response was received and so the DCS wrote to him again on 18/06/21, providing a third deadline of 02/07/21. There continued to be no response. The DCS wrote to him again on 13/07/21 providing a further deadline of 27/07/21. There continued to be no response.</p> <p>A fifth email was sent on 16/08/21, which was also not responded to. The email informed Mr Beirao Magro Gomes Sanches that, given his lack of engagement, the matter had been referred to the GDC's FtP department for assessment.</p> <p>The Committee accepted Mr Hyde's evidence that there had been no response at all from Mr Beirao Magro Gomes Sanches.</p> <p>The Committee was satisfied that Mr Beirao Magro Gomes Sanches was under a professional duty to respond to the DCS regarding the complaint. This duty existed under the complaints handling provisions of Standard 5 of the Standards and also under Standard 9.4, which states "You must cooperate with any relevant formal or informal inquiry..."</p> <p>Accordingly, the Committee found this charge proved.</p>
4.	<p><i>From 13 June 2022 to 30 December 2022, you failed to cooperate with an investigation conducted by the GDC by not providing the GDC with:</i></p>
4.(a)	<p><i>any or sufficient evidence of indemnity; and</i></p> <p>Found proved.</p>
4.(b)	<p><i>employment details.</i></p> <p>Found proved.</p>



The Committee accepted the evidence of Ms Rasul regarding the communications which the GDC sent to Mr Beirao Magro Gomes Sanches as part of its investigation into his fitness to practise and his lack of response to those communications.

On 30/05/22 the GDC first wrote to the Mr Beirao Magro Gomes Sanches to request his employment details, indemnity, and patient records for Patient A, giving a deadline of 13/06/22. No response was received and a follow-up email was sent to him on 28/07/22 providing a new deadline for providing the requested information of 04/08/22. No response was received and further requests with extended deadlines were sent to him on 17/11/22 and 02/12/22. No response was received and a further letter was sent on 16/12/22 providing an extended deadline of 30/12/22. No response was received by this date or subsequently.

The Committee was satisfied that Mr Beirao Magro Gomes Sanches was under a professional duty to respond to the GDC's investigation by providing the GDC with the requested evidence of indemnity and employment details, as set out under 9.4.1 of the Standards: "*If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.*" Mr Beirao Magro Gomes Sanches did not do so. He had not responded at all to the GDC's investigation and has not otherwise engaged in these proceedings.

Accordingly, the Committee found charges 4(a) and (b) proved.

Stage two 21 August 2024

19. At this stage of the hearing, the Committee shall decide whether Mr Beirao Magro Gomes Sanches's fitness to practise as a dentist is currently impaired by reason of misconduct and, if so, what action (if any) to take in respect of his registration.
20. Ms Bird submitted that the facts found proved amount to misconduct and that Mr Beirao Magro Gomes Sanches's fitness to practise is currently impaired by reason of that misconduct. She submitted that the only appropriate outcome in this case is that of erasure.
21. The Committee accepted the advice of the Legal Adviser.
22. The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, last revised December 2020) (the "ISG").

Misconduct

23. Misconduct connotes a serious falling short of the standards reasonably expected of a dental professional. In assessing whether the facts found proved amount to misconduct, the Committee had regard to the following principles from the *Standards*:



7.1 You must provide good quality care based on current evidence and authoritative guidance

9.4 You must co-operate with any relevant formal or informal inquiry and give full and truthful information

24. Mr Beirao Magro Gomes Sanches failed to provide an adequate standard of care to Patient A over a four year period in relation to complex, invasive and irreversible restorative treatment. Whilst his surgical placement of a total of ten implants (four to the upper jaw in 2016 and six the lower jaw in 2019) appeared to be satisfactory, there were substantial failings in relation to the restorative work which he placed on top of those implants.
25. Patient A faced repeated complications with her restorative work over a period of years, with her bridgework fracturing or breaking and some of her supporting teeth becoming chipped or fractured. This was the result of Mr Beirao Magro Gomes Sanches's sustained failure to consider her occlusion and to assess the case holistically, both when initially planning the treatment in 2016 and 2019 and when assessing the complications which repeatedly presented themselves. He failed to inquire why the complications kept arising and failed to reach a diagnosis. Patient A's treatment ultimately remained incomplete and she needed remedial work from other dentists.
26. The Committee accepted the opinion evidence of Professor Brook that this fell far below the standards reasonably expected of Mr Beirao Magro Gomes Sanches.
27. In respect of his radiography practice, Mr Beirao Magro Gomes Sanches failed to report on a total of 13 radiographic images which he had requested taken for Patient A over a period of three years. This was in breach of a mandatory statutory requirement under the IRMER regulations and the Committee accepted the opinion evidence of Professor Brook that it fell far below the standards reasonably expected of Mr Beirao Magro Gomes Sanches.
28. Mr Beirao Magro Gomes Sanches also failed to obtain Patient A's informed consent for the treatment which was provided in 2016. The information he provided to her was generic and some of it was not relevant to her. Moreover, when obtaining her consent for the bone graft, he incorrectly stated the graft materials were "synthetic" when they were in fact derived from Cow bone and Pig collagen. This was in breach of Patient A's right to know what was to be implanted into her, with the irreversible use of animal products potentially being objectionable on religious or ethical grounds. The Committee accepted the opinion evidence of Professor Brook that this fell far below the standards reasonably expected of Mr Beirao Magro Gomes Sanches.
29. In the Committee's judgment, Mr Beirao Magro Gomes Sanches's failings in the clinical care and treatment which he provided to Patient A was in substantial breach of the GDC's Standards and was sustained and repeated over a period of years. The Committee was satisfied that this amounted to misconduct.

30. Patient A's eventual complaint to the DCS arm of the GDC was serious. Her complaint had been escalated to the DCS for investigation and resolution, in accordance with an established dispute resolution process of the profession. Despite repeated attempts by the DCS to communicate with Mr Beirao Magro Gomes Sanches, he failed to engage at all in the process. His complete non-engagement continued as part of the GDC's ensuing investigation into his fitness to practise. To date there has been no response from him at all and he still has not provided the proof of his indemnity and employment details which were repeatedly requested of him. The Committee accepted the opinion evidence of Professor Brook that Mr Beirao Magro Gomes Sanches's non-engagement and non-cooperation fell far below the standards reasonably expected of him.
31. In the Committee's judgment, the non-engagement with both the DCS and the GDC were serious breaches of fundamental GDC Standards which clearly amounted to misconduct.

Impairment

32. The Committee considered whether Mr Beirao Magro Gomes Sanches's misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare appropriate standards of conduct and behaviour so as to maintain public confidence in the profession and in this regulatory process.
33. In the Committee's judgment, Mr Beirao Magro Gomes Sanches's clinical failings would be remediable through learning, reflection and evidence of embedded improvement in practice. Because he has not engaged in these proceedings at all, he demonstrates no evidence whatsoever of any remediation. There is no evidence of any insight, remorse or reflection. This means that the Committee cannot be satisfied that the risk of repetition is low. Indeed, in the Committee's judgment, on the material available to it, there would be a real risk of repetition (and therefore harm to patients) should Mr Beirao Magro Gomes Sanches be allowed to practise without any restriction on his registration. He had failed to provide an adequate standard of care to Patient A over a period of years which fell far below the standard expected.
34. Further, Mr Beirao Magro Gomes Sanches's failure to show any insight or remorse for his failings in Patient A's care engages the wider public interest, given the seriousness of those failings, the extensive period of which they were sustained and repeated and the harm which had been caused to the patient. Public confidence in the profession and its regulation would be undermined if no finding of impairment were to be made to mark the seriousness of the clinical aspects of Mr Beirao Magro Gomes Sanches's misconduct.
35. Mr Beirao Magro Gomes Sanches's failures to engage with both the DCS and the GDC appear to be attitudinal and would therefore be more difficult to remedy. His misconduct in this regard is compounded by his continued lack of engagement with his regulatory body. His misconduct represents a continuing state of affairs. He

appears to have abandoned his regulatory obligations in the United Kingdom. By not engaging for whatever reason, he fundamentally undermines the regulatory role of the GDC and its ability to investigate his fitness to practise. He shows himself as unwilling to be regulated as a healthcare professional and thereby undermines public confidence in the profession and its regulation. His non-engagement was in breach of a fundamental tenet of the profession and brings the profession into disrepute.

36. The Committee determined that there is a real risk of repetition of the non-engagement aspects of Mr Beirao Magro Gomes Sanches's misconduct. Indeed, in the Committee's judgment it is highly likely that Mr Beirao Magro Gomes Sanches would continue to not engage with the GDC as part of its regulatory processes into this and other matters. In any event, public confidence in the profession and its regulation would be seriously undermined if no finding of impairment were to be made to mark the seriousness of his non-engagement and to declare such behaviour as unacceptable within the profession.
37. Accordingly, the Committee determined that Mr Beirao Magro Gomes Sanches's fitness to practise as a dentist is currently impaired by reason of misconduct in respect of both the clinical and non-engagement matters. There would be a real risk of harm to the public should Mr Beirao Magro Gomes Sanches be allowed to practise without any restriction on his registration and public confidence in the profession would also be undermined if no finding of impairment were to be made.

Sanction

38. The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and the wider public interest in accordance with the GDC's overarching objective of public protection and the promotion of standards within the profession.
39. In assessing what action, if any, to take in respect of Mr Beirao Magro Gomes Sanches's registration, the Committee had regard to the aggravating and mitigating factors present in this case.
40. The aggravating factors include actual harm caused to Patient A and a remaining risk of harm to other patients, should Mr Beirao Magro Gomes Sanches be allowed to practise without any restriction on his registration; his misconduct was sustained and repeated over a lengthy period and, in respect of the non-engagement, represents a continuing state of affairs; the clinical aspects of the misconduct were also repeated in that the restorative treatment not only in respect of the 2016 treatment to the upper arch but also in respect of the 2019 treatment to the lower arch; there has been a blatant or wilful disregard for the role of the GDC and the systems regulating the profession and there is a complete lack of insight demonstrated.
41. The Committee could not identify any mitigating factors save that there were no previous findings against him.



42. In accordance with the need to act proportionately, the Committee considered the question of sanction in ascending order of severity.
 43. To conclude this case with no further action or a reprimand would be wholly inappropriate in the Committee's judgment, given the risk of repetition and the seriousness of Mr Beirao Magro Gomes Sanches's misconduct. A reprimand would be insufficient to protect the public and to maintain wider public confidence the profession.
 44. The Committee next considered whether conditions of practice could be formulated which would be workable, measurable and proportionate. Whilst the clinical failings in this case might be remediable through conditional registration with engagement from Mr Beirao Magro Gomes Sanches, there is no engagement from him. In any event, the non-engagement aspects of his misconduct self-evidently mean that the Committee could have no confidence in Mr Beirao Magro Gomes Sanches's compliance and are anyway too serious for conditions to be the appropriate sanction. Moreover, no conditions could be formulated to address the nature of misconduct in this regard, as any conditions would simply require him to comply with basic professional standards to which his registration is already subject.
 45. The Committee next considered whether to direct that Mr Beirao Magro Gomes Sanches's registration be suspended for a period of up to 12 months with or without a review. In assessing the sufficiency of suspension, the Committee also had regard to erasure.
 46. In the Committee's judgment, each of the factors indicated under paragraph 6.28 of the ISG in support of suspension are engaged in this case except for "*there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).*"
 47. In the Committee's judgment, there is evidence of a professional attitudinal problem. Mr Beirao Magro Gomes Sanches has repeatedly demonstrated a fundamental attitude of non-cooperation or non-engagement with the regulatory process, whether as part of a mandatory dispute resolution scheme for patients or in response to an investigation into his fitness to practise. This attitude is fundamentally incompatible with professional registration. It frustrates the entire regulatory process and means that neither the public nor the profession can have any confidence in his fitness to practise. It is not open to him to ignore the requests of his regulatory body. In the Committee's judgment, erasure is the necessary and proportionate sanction in response to his misconduct.
 48. The Committee therefore directs that the name of Mr Beirao Magro Gomes Sanches be erased from the Register.
 49. The Committee now invites submissions on the question of an immediate order.
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50. The order for interim suspension on Mr Beirao Magro Gomes Sanches's registration is hereby revoked.



51. The Committee was satisfied that it is necessary for the protection of the public and is otherwise in the public interest to order that Mr Beirao Magro Gomes Sanches's registration be suspended forthwith under section 30(1) of the Dentists Act 1984. It would be inconsistent with the decision the Committee has reached not to make an immediate order and the reasons for this are the same as set out in the substantive decision.

52. The effect of this order and the above determination is that Mr Beirao Magro Gomes Sanches's registration shall be immediately suspended upon this decision being served on him. Unless he exercises his right of appeal, his name shall be erased from the Register upon the expiry of the 28-day appeal period. Should he exercise his right of appeal, this immediate order shall remain in force pending the disposal of the appeal.

53. That concludes this hearing.